26 Suicide Intervention

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It is dismissal time, and a 17-year-old student is attempting to give away her 3-month-old child. She has approached the school resource officer (SRO) and asked his assistance in getting the baby to the child's godmother. She states that she wants the child's godmother to care for her baby after she is gone. The SRO recognizes that this student is giving away her most prized possession and calmly asks her to accompany him to the nurse's office, where she will be able to call the child's godmother. At this point, the school psychologist is summoned and the principal alerted. The psychologist collaborates with the principal, nurse, and SRO, and assesses this student as being at risk for suicidal behavior. This student has a history of prior suicidal behavior and episodes of depression. In addition, a search of her purse has revealed two bottles of Tylenol. Three hours pass as the school attempts to contact the father and the aunt (the only two emergency names in the student's file). During this time the student has grown increasingly agitated. The student has had to be restrained in handcuffs by two local police officers, who were called to assist school staff after efforts to reach the father and aunt proved futile. Soon after the police arrive, the student's father arrives. Embarrassed by his daughter's screams, he clearly wants to take her home. The police instruct the psychologist to release the student to the father. After collaborating with team members, the principal informs the police that school staff has assessed the student as being at high risk for suicidal behavior and that they have decided not to release the student to the father if he simply intends to take her home. While the police confer, school staff uses this opportunity to try to convince the father that his daughter needs an emergency mental health evaluation. However, the father reiterates his intention to "just take her home." At this point the principal informs the father that if he insists on taking his daughter home, school policy requires the principal to alert child protective services. With this information, seeing how irrational his daughter has become, and knowing of her prior suicide attempts, the father is now convinced of the need for mental health assistance. When the police return, the father informs them that he wants his daughter to be escorted to the local mental health facility.

Every day in America, school personnel respond to situations like the one described above. Although such situations require an immediate response, it is important to acknowledge that students do not become suicidal suddenly and without warning. They get there after traveling down a long road (a continuum) of self-destructive behavior. Where educators intercept the child on this road determines their responsibilities. From the outset of the referral, school mental health professionals must project confidence, competence, and authority while maintaining a calm and empathetic manner. Youths must feel connected with the caregiver, at a most vulnerable time, to trust that the staff member will advocate for their well-being.

As was illustrated in the situation described above, suicide intervention is complicated. This chapter provides information that will assist in this process. It begins with a discussion of the issues that make suicide intervention unique. This is followed by an exploration of developmental and cultural issues. Finally, and perhaps most importantly, the chapter concludes with a detailed exploration of suicide intervention.

Unique Crisis Issues

Suicide intervention is a special form of crisis intervention, and suicide intervenors must be prepared to address several unique issues, including the fact that the stakes are especially high during a suicide intervention. This form of crisis intervention is quite literally a life and death matter. Consequently, crisis intervenor stress is especially high during a suicide intervention. When combined with the stigma and taboo surrounding suicide, it is not surprising that many caregivers are reluctant to provide suicide intervention services. Obviously, this fact is most unfortunate because the crisis of attempted or completed suicide is preventable. Such prevention requires not only a willingness to accept a heavy responsibility, but also knowledge of suicide warning signs and risk factors. Thus, this section explores the unique warning signs and risk factors associated with suicidal ideation and behaviors. This section also explores some of the legal issues associated with suicide intervention.

Warning Signs of Youth Suicide

Individuals who are thinking about suicide usually give signals (Ramsay, Tanney, Tierney & Lang, 1996). It has been widely reported that four out of five suicide victims display warning signs, often providing verbal clues (Hyde & Forsyth, 1978). Elementary age children do not typically self-refer, and it is often their behaviors that provide the clues to their intentions. Thus, knowledge of warning signs is a suicide intervention prerequisite. Effective school suicide intervention plans need to ensure that students, parents, and school personnel are knowledgeable of warning signs and instructed on how to refer the individual for appropriate assessment. Some common warning signs of youth suicide are summarized below.

Suicide threats. Threats may be direct (e.g., "I want to die," or "I am going to kill myself") or, unfortunately, indirect (e.g., "The world would be better without me,"

"Nobody will miss me anyway"). In adolescence, indirect clues can be offered through joking or through references in school assignments, particularly creative writing, or artwork. In concrete and preoperational children, indirect clues may come in the form of acting-out or violent behavior often accompanied by suicidal/homicidal threats (Davis & Brock, 2002).

Suicide plan, method, and means. Suicidal thoughts must be distinguished from actual behaviors (Beebe, 1975). The greater the planning, the greater the risk (Ramsay et al., 1996). In evaluating the suicidal potential of a student, the lethality and availability of the means and the level of sophistication of the plan (including the developmental level of the interviewee) must be taken into account (Davis & Brock, 2002). Familiar methods for younger children include running into traffic; jumping from high places; and cutting, scratching, or marking their body.

Previous attempts. Adolescents with a history of prior suicide attempts are at increased risk for a variety of negative outcomes, including repeat attempts; psychiatric symptoms; and academic, social, and behavioral problems (Shaffer & Piacentini, 1994). Fifteen percent of individuals with a history of one or more suicide attempts will go on to kill themselves (Maris, 1992). It is estimated that 26 to 33% of adolescent suicide victims have made a previous attempt [American Foundation for Suicide Prevention (AFSP), 1996].

Making final arrangements. In adolescents, this behavior might include giving away prized possessions (e.g., jewelry, clothing, a journal, or even a child). It seems likely that preoperational elementary children lack the cognitive skills necessary to make final arrangements, so this warning sign is typically not observed.

Symptoms of depression. When symptoms of depression include pervasive thoughts of helplessness and hopelessness, a child or adolescent is at greater risk for suicide (Beck, 1986; Glantz, Haas, & Sweeney, 1995).

Risk Factors of Youth Suicide

Youth suicides are multidimensional and complex behaviors with many associated risk factors, including psychopathological disorders, familial factors, biological factors, environmental factors, and situational crises (Berman & Jobes, 1991; Davis & Brock, 2002; Moscicki, 1995).

Psychopathological disorders. There is strong evidence that more than 90% of children and adolescents who commit suicide have experienced a mental or emotional disorder before their death (Conwell et al., 1996; Shaffer et al., 1996). The disorders most closely associated with suicide are affective disorder and substance abuse (Brent & Perper, 1995). Intoxication is present in half of all youth suicide (Moscicki, 1995). Individuals with a history of alcohol abuse are six times more likely to die by suicide than the general population (Ramsay et al., 1996).

The most frequently diagnosed mood disorders are major depressive disorder, dysthymic disorder, and bipolar disorder (U.S. Department of Health and Human Services, 1999). Estimates are that 60% of suicide victims are diagnosed with depression. Thus, in the scenario described at the beginning of the chapter, the student's history of depression added to the concern. There is substantial comorbidity of depression with conduct problems and drug or alcohol abuse among high school students reporting suicide attempts. Comorbidity increases the risk of a suicide attempt beyond that found among adolescents who report these disorders in isolation from one another (Wagner, Cole, & Swartzman, 1996).

Familial factors. Family characteristics that increase youth suicide risk include a family history of suicide and of medical and/or psychiatric illness. Economic stress, significant family strife, and family loss are also associated with increased risk, and suicidal children experience more parental separations, divorces, and remarriages (Davis & Brock, 2002; Davis & Sandoval, 1991). Suicidal adolescents perceive their families as being less cohesive and more disengaged. Conflict and violence occur at increased rates within these families (King et al., 1995).

Biological factors. Although biological risk factors are not at present particularly useful in identifying suicide risk, it is important to acknowledge that neuro-chemical studies provide evidence of serotonergic dysfunction in adult suicide attempters and completers (Moscicki, 1995). Perhaps at some point in the future, such factors may prove helpful to school suicide prevention and intervention.

Environmental factors. Perhaps the strongest situational risk factor, at least in the United States, is the presence of a firearm (Brent et al., 1991; Kellerman et al., 1992). Use of a firearm is the most common method of suicide among male and female, younger and older adolescents and for all races (Karchur, Potter, James, & Powell, 1995). Many believe that the increased rate of youth suicide over the past four decades is largely related to the use of firearms as a method [American Association of Suicidology (AAS), 1996]. Guns in the home, particularly loaded guns, are associated with increased risk for suicide by youths, both with and without identifiable mental health problems or suicidal risk factors (Brent et al., 1993). Although many gun owners reportedly keep a firearm in their home for "protection or self defense," 83% of gun-related deaths in these homes are the result of a suicide, often by someone other than the gun owner. In general, states with stricter gun laws have lower rates of suicide (AFSP, 1996).

Situational crises. As high as 40% of youth suicidal behaviors appear to have identifiable antecedents (Davis & Brock, 2002). It is useful to consider suicide as comprising two related factors. The first, an acute situational crisis, is a precipitating event, an event of emotional relevance to a particular adolescent. When this co-occurs in a youth with a second factor, such as chronically poor coping skills, risk is greatly increased (AAS, 1996).

The types of crises, or stressors, most often associated with suicidal behavior are those that result in some type of loss. In particular, loss that is judged as significantly devaluing one's life is associated with suicide (Ramsay et al., 1996). The most common situational crisis precipitating adolescent suicide attempts are interpersonal crises. In this situation, the intent of the behavior appears to be to effect change in the behaviors or attitudes of others (AAS, 1996). Oftentimes, in the aftermath of a suicide, these situational factors may be mistakenly viewed as a cause of suicide. It is only when combined with other risk factors, such as those just discussed, however, that situational crises create the conditions that lead to suicide (Moscicki, 1995). Examples of other situational crises that *may* precipitate youth suicide include death (especially traumatic death) of a significant other, parental divorce, family moves, incarceration, trouble at school, family violence, parental arguments, physical and sexual abuse, running away from home, and exposure to suicidality in others (AAS, 1996; Brock & Sandoval, 1996; Davis & Brock, 2002; Davis & Sandoval, 1991; Moscicki, 1995; Ramsey et al., 1996).

Legal Issues in Suicide Intervention

Landmark cases, such as Kelson v. The City of Springfield (1985), have helped to define the responsibilities of schools and their employees when confronted with a suicidal student. School districts have been found liable for not offering suicide prevention programs, providing inadequate supervision of a suicidal student, and failing to notify parents when their children were suicidal (Wyke v. Polk County School Board, 1997). The liability issues are foreseeability and negligence. That is, if a child writes or talks about suicide, adults (particularly trained adults such as school psychologists or counselors) should be able to foresee a potential suicide. It is negligent on the part of the school not to notify parents or guardians when students are known to be suicidal. It is also negligent not to supervise the student closely (Poland & McCormick, 1999). Even when a student denies suicidal intent, if the collaborative team suspects the child to be suicidal, they have an obligation to notify parents (Eisel v. Board of Education of Montgomery County, 1991).

Although school district personnel should intervene whenever a child threatens suicide or manifests signs of the intent to commit suicide, most courts have recognized that schools are not equipped to do the necessary in-depth counseling and treatment of children. Rather, the courts hold that school personnel are in a position to make referrals and have a duty to secure assistance from others, with parental involvement, when a child is at risk (Davis & Sandoval, 1991).

Districts have a responsibility to provide adequate staff training in suicide prevention. Litigation against the schools has also occurred on the rare occasion of a suicide completion after a student was disciplined (suspended or expelled). Situational crises as precipitating events have already been discussed in this chapter. School mental health professionals can play a significant role in providing adequate training for all school staff and collaborating with administrators when students are involved in serious discipline procedures.

Developmental Factors

In 1997, people under age 25 (Hoyert, Konanek, & Murphy, 1999) committed 14% of all suicides. Suicide rates for those 15 to 19 years old are 300% higher than those same age peers of the 1950s, but have remained largely stable at these higher levels since 1980. Alarmingly, the suicide rates for those between the ages of 10 to 14, however, have increased 196% in the last 15 years (AAS, 1996; Peters, Konchanek, & Murphy, 1998).

Research shows that mortality from suicide, which increases steadily through the teen years, is the third leading cause of death for youths between the ages of 15 to 24 and fourth for those aged 10 to 14 (Hoyert et al., 1999). Among 15 to 19 year olds, for every female suicide there are 4.4 male suicides. Among 20 to 24 year olds, this ratio increases to 6.8:1. Conversely, among 10 to 14 year olds this ratio is the smallest: 2.7 male suicides for every female suicide (AAS, 1996). It has been estimated that there are more than 100 youth suicide attempts for every youth suicide (Ramsay et al., 1996) and, in the 15- to 19-year-old age group, girls make two of every three of these attempts (U.S. Department of Health and Human Services, 1999).

Especially when dealing with younger students at risk for suicide, it is important to be aware of a cognitive developmental perspective. Normand and Mishara (1992) suggested that youth understanding of the concept of suicide is clearly related to their age as well as their concept of and experiences with death. A more recent paper suggested that all school children have some general knowledge about suicide (Mishara, 1999). While studies of the progression of children's understanding of suicide are rare, there is a more substantial body of literature on the development of ideas about death. Piagetian theory states that, in the formal operational period, death is seen as not only irreversible, but also as personal. However, Orbach and Glaubman (1979) caution:

> … many children show a split in the death concept: they may have a mature concept of impersonal death, but a rather childish concept of their own personal death. Only the exploration of the emotional and personal aspects of the death concept is of value diagnostically and therapeutically. (p. 677)

In the assessment of suicide risk, school mental health professionals are cautioned that, when students are thinking about hurting themselves, it is best to assume they are not thinking logically. It would not be unusual for any student, sometimes even as old as 16, to view death as magical, temporary, and reversible. This situation is illustrated in the following scenario:

> An eighth-grade girl comes into the school psychologist's office on Friday as school lets out. When the psychologist says, "I'll see you on Monday," the student responds, "No you won't." After identifying that

the student is thinking of suicide, the psychologist conducts a suicide risk assessment. During the assessment phase the psychologist inquires why the student wants to die. She angrily responds: "to hover over my coffin and watch my mother cry!" The psychologist responds: "I do not know much about death, but I do know there is no hovering. You will not ever know if your mother cried because you will be dead. Now I am going to get some help for you today, and when you are feeling better we will begin working together on some better ways to cope with your anger toward your mom."

Ethnicity, Cultural Factors, and Sexual Orientation

The suicide rate for white males (15 to 24) has tripled since 1950, and the rate for white females (15 to 24) has doubled. Although data regarding suicidal behavior among minority youths are very limited (Roberts, Chen & Roberts, 1997), recent CDC studies have identified at risk populations previously unrecognized. Between 1980 and 1992 the suicide rate for African American males (10 to 14) increased 300% while the rate for white females (10 to 14) increased almost 240% (Karchur et al., 1995).

Overall, African American male adolescents (15 to 24) have shown the greatest increase in suicide completion rates in the 1990s relative to other races and ethnicities (AAS, 1996). Their rate has risen by 67% over the past 15 years (AFSP, 1996). Risk factors for African American suicide include being male, substance abuse, psychiatric disorder, antisocial behavior, and homosexuality. Protective factors that mitigate the risks of suicide include religious affiliation and social support (Gibbs, 1997).

Recent data suggest that, in 1997, Mexican American students had the highest rates of suicidal ideation and behaviors (Kann et al., 1998) and were more likely than other students to attempt suicide (U.S. Department of Health and Human Services, 1999). However, this has yet to translate into a substantial increase in completed suicides. Heightened levels of acculturative stress may result in critical levels of suicidal ideation in Mexican American adolescents (Hovey & King, 1996).

The Native American male adolescent and young adult are still the highest risk group in the United States. The rate in Indian Health Service areas was the highest in the nation at 62.0 per 100,000 (Wallace, Calhoun, Powell, O'Neil, & James, 1996). The problem of acculturation has been proposed as one of the major causes of depression and suicidal behavior among Native Americans. The majority of research, however, reports that Native American individuals who attempt or complete suicide mention precipitating causes such as grief over loss and quarrels with relatives and friends (Lester, 1997).

Gay and lesbian youths are 200 to 300% more likely to attempt suicide than other young people, and they may account for up to 30% of completed youth suicide annu-

ally (Gibson, 1989). Recent analyses of the Youth Risk Behavior Survey, compiled by the state of Massachusetts (1997), revealed that adolescents who identified themselves as gay, lesbian, or bisexual reported significantly higher rates of considering suicide than their heterosexual peers (54% vs. 22%); making a suicide plan (41% vs. 18%); actually attempting suicide (37% vs. 8%); and of requiring medical attention for a suicide attempt (19% vs. 3%).

We share Moscicki's (1995) observation that, in general, research on this issue is complicated by the lack of accurate information on the true rate of homosexuality in the population and the strong emotions it generates in many otherwise objective discussions. When gay and lesbian students are referred, practitioners assessing suicide risk are advised that this may be a population, similar to the Native American youths, with higher rates of victimization, drug and alcohol abuse, and familial rejection.

Today's school mental health professional faces a population of referred youths that are growing in racial and cultural diversity. Language and cultural differences increasingly complicate the already complex referral process, as illustrated in the following scenario:

> Nazia lived with her mother and appeared to be a typical Pakistani-American teenager. She had friends from diverse cultures and on weekends enjoyed attending parties and rap concerts. Recently, her mother became quite anxious about what might become of her 14-year-old daughter if something tragic should happen to the mother. The mother was a Pakistani-in-America. She only spoke in her native language, only dressed in traditional clothes, and possessed only Pakistani friends. To resolve her dilemma, the mother chose to arrange a marriage for her daughter. One night, a local, wealthy 21-year-old university student showed up at Nazia's door ready to exchange vows. After a highly emotional outburst, Nazia consented. The next day, at school, while being consoled by her friend in the school bathroom, Nazia attempted suicide by swallowing a bottle of Tylenol. Her friends brought her to the school nurse who immediately called the paramedics.

Practitioners will need to familiarize themselves with the many cultures represented in their school districts and strengthen their skills with cultural awareness. School psychologists will also need to use interpreters when necessary and to become aware of appropriate community agencies that focus on the needs of specific populations.

Crisis Intervention

Poland (1989) has indicated that school suicide intervention responsibilities include: (a) detecting suicidal students, (b) assessing suicide threat severity, (c) notifying parents, (d) attaining needed mental health services, (e) supervising the suicidal

student, and (f) providing follow-up at school. We now explore these and other general suicide intervention strategies.

Collaborate. School mental health professionals dealing with suicidal youth should seek support and collaboration from their colleagues (Poland, 1989, 1995). The intervention process is fraught with unexpected developments. Having the support and consultation from an administrator and one other staff member (perhaps the school nurse, counselor, or social worker) is both reassuring and prudent because difficult decisions are often necessary when advocating for a suicidal youth.

Assign a "designated reporter." Schools should identify one or more individuals to receive and act upon all reports from teachers and other staff about students who may be suicidal (Davis & Sandoval, 1991). This individual is frequently a school psychologist or counselor.

Supervise the student. School psychologists and counselors should inform all students they counsel of the following: "There are three pieces of information that, if you tell me, I must tell someone else in order to help you. These are (a) if you are being abused, endangered, or neglected in any way, anywhere; (b) if you are planning to harm yourself; or if (c) you are planning to hurt another." In many cases, when students confess their suicidal intentions, they are unaware that the school psychologist, or any educator for that matter, is not bound by confidentiality and is obligated to report their comments or actions to their parents (or protective services, to be discussed later). It is always best to inform the student what you are going to do every step of the way. Solicit the student's assistance when appropriate. Under no circumstances should the student be allowed to leave school or be alone (even in the restroom). Reassure and supervise the student until a parent can assume responsibility. It may be appropriate to solicit the aid of collaborators to monitor the student while the psychologist or counselor seeks a phone in private.

Mobilize a support system. The school must establish a support system that will carry the youth through the difficult challenges ahead long after the student leaves the school. Assessment of that support system will also contribute to evaluating the student's risk. It is often sensible to just ask the student: "Who do you want and who do you think will be there for you now?" and assist the student in achieving that support. It is important for the student to feel some control over his or her fate.

Implement no-suicide contracts. In our experience, "no-suicide" contracts are effective in helping to prevent youth suicide. Examples can be found in Poland (1989, 1995) and Davis and Sandoval (1991). This type of contract helps students take control over their suicidal impulses and reduces the anxiety of both students and the school mental health professional (Berman & Jobes, 1991; Davis & Sandoval, 1991). In cases where the suicide risk is judged low enough not to require an immediate treatment (e.g., there is only ideation and no suicide plan), a no-suicide contract is still recommended to provide the student with alternatives should his or her suicide risk level

increase in the future. Such a contract is a personal agreement to postpone suicidal behaviors until help can be obtained. Poland (1989) suggested "each contract be tailor made for the student. The most official looking school stationery should be used. The contract should be signed by the student and the counselor and the student should be given a copy" (p.82). However, contracts should not be used in isolation (Barrett, 1985). The contract can also serve as an effective assessment tool. If students refuse to sign, they cannot guarantee they will not hurt themselves. The risk assessment immediately becomes high risk, and the student must be constantly supervised until a parent can assume responsibility.

Suicide-proof the environment. Whether or not a child is in imminent danger, it is recommended that both the home and school be suicide-proofed (Davis & Sandoval, 1991). Before the child returns home and thereafter, all guns, poisons, medications, and sharp objects must be removed or made inaccessible.

Call police. All school crisis teams should have a representative from local law enforcement. If a student resists, becomes combative, or attempts to flee, law enforcement can be of invaluable assistance. In some cases they can assume responsibility for securing a "72-hour hold," which will place the youth in protective custody up to three days for psychiatric observation.

Document. Every school district should develop a documentation form for support personnel and crisis team members to record their actions in responding to a suicidal student. A sample documentation form is provided in Figure 1. Information should include reasons for referral and actions taken.

A Suicide Intervention Model

The intervention component of the Los Angeles Unified School District's (LAUSD) Youth Suicide Prevention Program mandates four steps. First, the intervenor must assess the student's risk for suicidal behavior. Such data will determine the course of action. Second, the intervenor has a duty to warn. This will involve notifying the student's parent or a protective service agency. Third, the intervenor has a duty to refer the students to the appropriate community resources. Typically, these will be professional mental health services. Finally, the intervenor must provide follow-up and support the family in accessing community resources. We now discuss each of these four components of the LAUSD's suicide intervention protocol.

1. Conduct a suicide risk assessment. Davis and Brock (2002) identify nine areas of questioning that the suicide risk assessment interview needs to address. These areas include suicide potential, suicide plan, past suicide attempts, affects and behaviors, family background, precipitating events, response from the support network, concept of death, and ego functions.

Figure 1

This form can be used to document the actions of school personnel when responding to a suicidal student.

Risk Assessment Referral Data

Referral Date: _____ (MO/DAY/YR) Time: _____

1. Student's Name: _____ (LAST / FIRST / MI)
2. School: _____ (LOC. CODE / SCHOOL NAME) Cluster: _____
3. Grade: _____
4. Birthdate: _____ (MO/DAY/YR) 5. Age: _____ 6. Sex: ___ M ___ F
7. Ethnicity: _____
8. Lives With: ___ A. Both Parents ___ B. Mother ___ C. Father ___ D. Other Guardian
9. Parent/Guardian Name: _____ (LAST / FIRST / MI)
10. Address: _____ (NUMBER / STREET / APT. NO.)
    City: _____ Zip: _____
11. Phone: Home (___) _____ Work (___) _____
12. Current Educational Program:
    ___ A. Regular ___ B. Gifted ___ C. Resource Specialist ___ D. Special Day Class ___ E. Other (Specify) ___ F. Magnet
13. Bilingual Status: ___ A. LEP ___ B. FEP ___ C. English Only
14. Student Referred by: (CHECK ONE OR MORE)
    ___ A. Self ___ B. Parent ___ C. Teacher ___ D. Counselor ___ E. Psychologist ___ F. SAAS Counselor ___ G. Nurses ___ H. Other (Specify)_____ ___ I. Student/Friend
15. Reason for Referral: (CHECK ONE OR MORE)
    ___ A. Direct Threat
    ___ B. Indirect Threat
    ___ C. Previous Attempt(s) Indicated
    ___ D. Giving Away Prized Possessions
    ___ E. Mood Swings
    ___ F. Sudden Changes in Behavior
    ___ G. Signs of Depression
    ___ H. Truancy or Running Away
    ___ I. Frequent Complaints of Illness or Bodily Aches
    ___ J. Drug or Alcohol Abuse
    ___ K. Other (Specify) _____
    ___ L. Current Attempt
    ___ M. Completion: Date _____
    ___ N. Update of Current RARD Date of Update: _____
16. Previous Risk Assessment Referral: ___ No ___ Yes
17. Data Recorded by (Case Carrier):
    ___ A. Counselor ___ B. Psychologist ___ C. Nurse ___ D. SAAS Counselor ___ E. Administrator ___ F. Other (Specify)_____
18. Intervention(s)/Outcome(s): (CHECK WHERE APPROPRIATE: SEE # 18 UNDER DIRECTIONS)
    ___ A. Parent Contact Made
    ___ B. Parental Brochure Provided
    ___ C. Referral to Community Agency
    ___ D. Child Abuse Form Filed (ENDANGERMENT)
    ___ E. Hospitalization
    ___ F. Other (Specify)_____
    ___ G. School Support Strategies
        ___ 1. Group Counseling
        ___ 2. Individual Counseling
        ___ 3. Peer Counseling
        ___ 4. Program Modification
        ___ 5. Other (Specify) _____
19. School Transfer (Specify School): _____ Date: _____

Figure 1 continued on p. 542

Figure 1 continued

Directions for Completing the Risk Assessment and Referral Data (RARD)

To be completed by counselor/site team member:

- All items are to be printed.
- **Referral Date/Time:** Indicate date/time referral is received by counselor/site team member.

Item Numbers: (INDICATE THE FOLLOWING:)

1. Student's last name, first name, and middle initial.
2. School's location code and name.
3. Student's current grade.
4. Student's date of birth.
5. Student's age in years.
6. Student's sex: place a checkmark next to "M" for male or "F" for female.
7. Write in student's ethnicity.
8. Person(s) with whom student lives: place a checkmark next to the appropriate person(s).
9. Parent/guardian last name and first name.
10. Parent/guardian complete address, including number, street, apartment number (if applicable), city, and zip code.
11. Parent/guardian home and work phone numbers. (Include area code.)
12. Student's current educational program: place a checkmark next to the word that best describes student's program. If the student's current educational program is not listed, indicate program by writing it next to the word "Other."
13. Student's bilingual status: place a checkmark next to the appropriate acronym or word that describes the student's status.
14. Person(s) who referred the student to the counselor/site team member: place one or more checkmarks next to the appropriate person(s).
15. The reason(s) student was referred to counselor/site team member: place a checkmark next to the appropriate reason(s). (A student can be referred for reasons other than for suicide warning sign. Suicidal behavior can emerge during an intake interview.)
16. Whether student has had a RARD form completed prior to current referral: place a checkmark next to the word "Yes" or "No."
17. The position of the person completing the RARD form: place a checkmark next to appropriate title.
18. The intervention(s)/outcome(s) that occurred with respect to this student's referral: place one or more checkmarks next to the appropriate outcomes. **NOTE:** Every referral requires A. Parent contact made and B. Parent Brochure provided and C. Referral to Community Agency, unless there are extenuating circumstances.
19. Student's school transfer: specify name of new school and date of transfer.

The experience of talking to a suicidal child can be extremely stressful for the designated reporter. Poland (1989) recommends the use of a Risk Assessment worksheet. Brock and Sandoval (1996) offer sample questions for interviewing the suicidal student (Table 1).

School psychologists and counselors, however, are often asked to make critical risk assessments under extraordinary time constraints. Thus, it is important for a risk assessment protocol to have a specific set of questions that will quickly and reliably obtain needed information (Ramsay et al., 1996). Questions often used as part of the LAUSD risk assessment protocol address the following:

- What warning sign(s) initiated the referral?
- Has the student thought about suicide (thoughts or threats alone, whether direct or indirect, may indicate low risk)?
- Have they tried to hurt themselves before (previous attempts may indicate moderate risk)?
- Do they have a plan to harm themselves now?
- What method are they planning to use, and do they have access to the means (these questions would indicate high risk)?
- What is the student's support system (including parents in the risk assessment is critical to determining the adequacy of the support system)?

Assessment instruments that may assist the school psychologist or counselor fall into two categories: those that measure suicide potential, and those that measure risk factors. Lists of these instruments, their uses, and their relative merits can be found in Davis and Brock (2002), Range and Knott (1997), and Davis and Sandoval (1991).

2. Notify parents. There is no question that parents must be notified (Poland, 1989). In addressing this aspect of suicide intervention, four critical questions need to be addressed: (1) Are parents available? (2) Are parents cooperative? (3) What information do parents have that might contribute to the assessment of risk? (4) What mental health insurance, if any, does the family possess? *If the parent is available and cooperative and the student is judged high risk,* the psychologist or counselor must provide them with community referral resources specific to where the family resides and based on health insurance status. With parental permission, the school psychologist or counselor should contact the agency, provide pertinent referral information, and follow up to ensure the family's arrival at the agency. If necessary, the school mental health professional should assist the parent in transporting the student to the agency. The psychologist should obtain a parent's signature on a release of information form and assist school staff in working with parents to develop a school support plan. All actions must be documented.

Table 1

Brock and Sandoval's (1996) Student Interview Model for Suicide Risk Screening

Engagement

- It seems things haven't been going so well for you lately. Your parents and/or teachers have said _____. Most teens/children would find that upsetting.
- Have you felt upset, maybe some sad or angry feelings you've had trouble talking about? Maybe I could help you talk about these feelings and thoughts?
- Do you feel like things can get better, or are you worried (afraid, concerned) things will just stay the same or get worse?
- Are you feeling unhappy most of the time?

Identification

- Other teenagers/children I've talked to have said that when they feel that sad and/or angry, they thought for a while that things would be better if they were dead. Have you ever thought that? What were your thoughts?
- Is the feeling of unhappiness so strong that sometimes you wish you were dead?
- Do you sometimes feel that you want to take your own life?
- How often have you had these thoughts? How long do they stay with you?
- Administer the Suicidal Ideation Questionnaire (Reynolds, 1988) or the Hopelessness Scale for Children (Kazdin et. al., 1986) to further qualify and/or quantify the seriousness of the student's suicidal thinking.

Inquiry

- What has made you feel so awful?
- What problems/situations have led you to think this way?
- Tell me more about what has led you to see killing yourself as a solution.
- What do you think it would feel like to be dead?
- How do you think your father and mother feel? What do you think would happen with them if you were dead?
- As appropriate, administer items from the Mental Status Exam (Davis & Sandoval, 1991).

Assessment

Current Suicide Plan

- Have you thought about how you might make yourself die?
- Do you have a plan?
- On a scale of 1 to 10, how likely is it that you will kill yourself? When are you planning to or when do you think you will do this?
- Do you have the means with you now, at school, or at home?
- Where are you planning to kill yourself?
- Have you written a note?
- Have you put things in order?

Prior Behavior

- Has any one that you know of killed or attempted to kill themselves? Do you know why?
- Have you ever threatened to kill yourself before? When? What stopped you?
- Have you ever tried to kill yourself before? How did you attempt to do so?

Resources

- Is there anyone or anything that would stop you?
- Is there someone whom you can talk to about these feelings?
- Have you or can you talk to your family or friends about suicide?

Summary

- Use a suicide risk assessment worksheet (e.g., Poland, 1989) to summarize the information gained during the interview(s).

Note
From Brock, S. E., & Sandoval, J. (1996). Suicidal ideation and behaviors. In G. G. Bear, K. M. Minke, & A. Thomas (Eds.), *Children's needs II: Development, problems, and alternatives* (pp. 361-374). Bethesda, MD: National Association of School Psychologists.

If the parents are unavailable and the student is judged high risk, then, at the discretion of the school site administrator, two members of the crisis team should escort the child to the nearest emergency mental health facility. They will also need to coordinate with the agency's social services department on continuing to attempt to contact a parent. Alternatively, school law enforcement, local police, or a mobile psychiatric response team may be asked to assist in transporting the suicidal youth.

Some parents are reluctant to follow through on crisis team recommendations to secure outside counseling for the suicidal youth. Cultural and language issues are frequent contributors to this reluctance. It is recommended that parents be given appropriate opportunity and encouragement to follow through before collaborating with crisis team members on when to proceed to the next step. The school crisis team must decide when it is appropriate to report a parent to child protective services if their reluctance is truly negligence and endangers the life of the child. If it is determined that parents *are uncooperative and the student is judged to be at high risk* for suicidal behavior, then the school should contact local law enforcement or child protective services and fill out a child neglect and endangerment report. If *the parents are uncooperative and the student is judged at low risk* for suicidal behavior, then it is recommended that the school obtain a parental signature on a "Notification of Emergency Conference" form (Poland, 1995). This form (provided in Figure 2) can document that the parents were notified of their child's suicidal assessment in a timely fashion.

There will be occasions *when a student does not want the parents notified*. When children are thinking of harming themselves, they are not thinking clearly and, therefore, may not be the best judge of their parent's response. The crisis team has only one decision to make: Will the child be placed in a more dangerous situation by notifying the parents? In such a situation, child protective services is typically notified. The parents must still be notified, and it is the challenge of school personnel to elicit a supportive response from parents. School personnel have been found liable in court for failing to notify parents when their child was suicidal (Poland, 1995; Poland & McCormick, 1999).

Parents often have critical information necessary to make an appropriate assessment of risk. Thus, it is critical to *include parents in the risk assessment*. This information may include previous school and mental health history, family dynamics, recent traumatic events in the student's life, and previous suicidal behaviors. Interviewing parents will also assist the psychologist and/or counselor in making an appropriate assessment of the support system that surrounds this student.

Finally, it is important to determine what mental health insurance the family has. This information is essential in directing families to appropriate community agencies. All modern mental health intake interviews include questions regarding insurance coverage, and it is wise for school psychologists and counselors to be aware of various local providers. If a student is directed to an emergency clinic, they may later require emergency transport to an appropriate HMO provider. This may not only further trauma-

Figure 2

This sample form can be used to verify that parents have been informed of their child's suicidal ideation.

I/We _____ , the parents of _____ were involved in a conference with school personnel on _____. We have been notified that our child is suicidal. We have been further advised that we should seek some psychological/psychiatric consultation immediately from the community. School personnel have clarified the district's role and will provide follow-up assistance to our child to support the treatment services from the community.

_____ _____

Parent or Legal Guardian School Staff Member, Title

Note

From Poland, S. (1995). Best practices in suicide intervention. In A. Thomas & J. Grimes (Eds.), *Best practices in school psychology III* (pp. 155-166). Washington, DC: National Association of School Psychologists.

tize a suicidal student (because most transports must be done under restraints), but also generate a significant bill for the family. It is certainly in the best interest of the student and family to limit the trauma of any student in need of emergency action.

3. Provide referrals. It is critical to identify and collaborate with community agencies before the crisis occurs. It is recommended that the school crisis team representative call the agency to provide accurate information that parents may omit. School districts have an obligation to suggest agencies that are nonproprietary or offer sliding scale fees.

4. Follow up and support the student and his or her family. Finally, it is important for school staff to provide ongoing modifications and support, perhaps utilizing student study teams. Such support might include: (a) referral for psycho-educational assessment, (b) individualizing classroom assignments, (c) assigning a peer tutor, (d) reducing academic demands, (e) participating in conflict or anger management programs, (f) participating in extracurricular activities, and (g) directing the family to appropriate community agencies.

Concluding Remarks

Research has revealed that youth suicide transcends all boundaries such as gender, age, ethnicity, geographical location, or socioeconomic status. This chapter discussed the risk factors and warning signs of youth suicide and provided the school mental health professional with general intervention strategies and a school intervention model.

As schools continue to be confronted with referrals of depressed and suicidal students, the role of the school mental health professional in providing leadership has never been so critical. These professionals face the following challenges:

- Promote primary prevention programs, such as substance/alcohol abuse, violence, dropout, and pregnancy programs, which address at-risk youths.
- Assist schools in linking with parents, community law enforcement, and mental health agencies.
- Advocate for school site crisis teams to implement and collaborate on appropriate intervention and postvention strategies.
- Provide staff development on youth suicide risk factors, warning signs, and referral processes.
- Advocate for the mental health needs of students who return to school following expulsion, mental health hospitalization, or other traumatic events.
- Support programs to reduce accessibility to firearms.

No school or community should have to suffer the devastation, confusion, uncertainty, and shock that occur in the aftermath of a suicide. Gandhi once said: "Be the difference that you want in the world." School mental health professionals can be such a difference in suicide prevention.

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